

Oral Histopathology

David E. Klingman, DMD

Diplomate, American Board of Oral and Maxillofacial Pathology

Diplomate, American Board of General Dentistry

Series 30 (14 cases)

Case	Features
Squamous papilloma	<ul style="list-style-type: none"> Papillary lesion with bland papillae/fronds, surface less keratinized (clinically would look more pink)
Squamous papilloma	<ul style="list-style-type: none"> Papillary lesion with bland papillae/fronds, surface more keratinized (clinically would look more white)
Varix with organizing thrombus	<ul style="list-style-type: none"> Single dilated vessel with thrombus in center, characterized by alternating lines of fibrin and hemorrhage; surface epithelium also identified
Lateral periodontal cyst	<ul style="list-style-type: none"> Radiolucency mesial to #30 mesial root and distal to/attached to root of retained #T, #29 missing (teeth respond to thermal testing, nonlingering) Cyst lined by simple/squamous epithelium with focal thickening
Suggestive of ameloblastoma	<ul style="list-style-type: none"> Features of ameloblastoma (basal palisading, reverse polarity), OKC (basal palisading, 5-8 cell layers, parakeratin) Cholesterol clefts, satellite cysts, ameloblastoma/odontogenic keratocyst-like hybrid nests/islands/daughter cysts in cyst wall
Glandular odontogenic cyst with Rushton bodies	<ul style="list-style-type: none"> Cyst with multiple mucus cells, focal thickening, microcystic spaces in cyst lining (all features of glandular odontogenic cyst) <i>Rushton bodies</i> (annular/ring-like eosinophilic to calcified structures) in the cyst lining and lumen
Central odontogenic fibroma	<ul style="list-style-type: none"> Stroma composed of fibromyxoid background, bland spindle cells (somewhat resembles dental pulp) with numerous epithelial odontogenic rests Recall the case from an earlier series of <i>peripheral odontogenic fibroma (World Health Organization type)</i> and consider this as the central version
Oral melanotic macule involving salivary duct	<ul style="list-style-type: none"> <i>Focal melanosis and melanin incontinence</i> (deposition of melanin and 'leakage' of melanin into connective tissue), in this case it involves a salivary duct The diagnosis of <i>melanosis</i> should not alert the clinician to a malignancy (some Oral Pathologists will include a comment line that the lesion is benign)
Pemphigoid	<ul style="list-style-type: none"> Complete separation of epithelium from connective tissue (<i>subepithelial vesiculo-ulcerative process</i>); there is in fact no connective tissue in this specimen
Lichen planus	<ul style="list-style-type: none"> Band-like lymphocytic infiltrate, liquefactive degeneration of the basal epithelial layer (blurs the interface between epithelium and connective tissue) and <i>exocytosis</i> (percolation of inflammatory cells into the epithelium)
Lichen planus with microgranulomata	<ul style="list-style-type: none"> Similar to previous case but with the presence of microgranulomas (epithelioid histiocytes and giant cells) interspersed in the inflammatory component This has been associated with a lichenoid reaction to some non-metallic restorative materials (such as composite) and was reported in the literature in a population of predominantly female patients in their 5th-7th decades
Lichen planus with Civatte/colloid bodies	<ul style="list-style-type: none"> This case of lichenoid mucositis highlights another histologic feature, the presence of eosinophilic 'globules' evident at high magnification near the basal epithelial cell layer – these are known as <i>hyaline</i> or <i>Civatte bodies</i>
Salivary duct cyst	<ul style="list-style-type: none"> A.k.a. <i>mucocele, retention type</i> this mucocele is lined by squamous to respiratory type (ciliated) epithelium
Foreign body, polarizable, c/w cement	<ul style="list-style-type: none"> The material is birefringent when viewed under polarized light; the clinical finding was that of a fragment of cement or some type of resin in the biopsy site